STATE OF CALIFORNIA

State Planning Grant Application
July 10, 2000

TABLE OF CONTENTS

PROJECT ABSTRACT

The California Health and Human Services Agency (CHHS) is submitting this planning grant proposal to the federal Health Resources and Services Administration (HRSA) to obtain funds that will leverage existing State resources to investigate options for achieving universal health care coverage in California. The size and diversity of the State provides an opportunity to explore the wide range of policy and implementation issues involved in addressing this goal. The proposed efforts in California are expected to inform other State efforts thus supporting the goals of the planning grant.

A recent report analyzing California data indicates the number of non-elderly uninsured persons in California reached 7.3 million in 1998. California's rate of uninsurance is significantly higher than that of the rest of the United States (24 percent as compared to 18 percent). California's relatively lower incidence of employer-based insurance may be a key factor in this higher rate of uninsurance.

The rising number of uninsured in California during the 1990's has refocused attention on the issues of the uninsured. The Executive and Legislative branches have introduced a number of reform measures to reduce the number of uninsured residents primarily through: expansion of existing public insurance programs; creation of new programs targeting selected populations, and reform of the insurance market targeting small businesses

During the past year, a legislative proposal -- SB 480 -- was enacted that calls upon the Secretary of Health and Human Services to examine options for achieving universal health coverage. The legislation calls for a process that involves both public and private sector stakeholder groups, and requires the Secretary to report to the Legislature by December 1, 2001.

The Health Care Options Project (HCOP) will assist policy makers to systematically explore policy options designed to achieve universal health care coverage. This process includes an in-depth exploration of reform options representing the full range of approaches to health care reform. In addition, we will engage in extensive quantitative and comparative analysis of selected approaches. All stages of this process will include both expert and stakeholder participation. Extensive public participation provides a crucial element to ensure an adequate representation of the perspectives and full consideration of the implications of the variety of approaches to achieving universal health care coverage. This project will culminate in reports to HRSA and the State Legislature to inform future health reform policy development and implementation.

The CHHS will lead this effort with the support of the California State Library. Other State departments participating in this effort include: the Department of Health Services, the Department of Mental Health, the Department of Finance, the Managed Risk Medical Insurance Board, the Department of Consumer Affairs, the Public Employees' Retirement System, the Department of Social Services, the Department of Managed Care, and the Department of Insurance. Resources for this effort include State staff, consultants, commissioned researchers and a modeling contractor.

Key elements of the California project are:

Synthesis of Existing Data and Research. CHHS will work in collaboration with the appropriate State departments to identify and assure that existing data sources are made available for analytic efforts, including development of reform options papers and modeling. CHHS will work in collaboration with the California State Library to support the development of literature reviews and background papers needed for the full exploration of selected policy options.

Development and Modeling of Coverage Options. The development and exploration of options include: (1) the commissioning of options papers by health policy experts to describe and assess a full range of alternative approaches; and (2) selection of a modeling contractor to analyze each proposed option in a way that will allow for comparison of the potential impacts across the options.

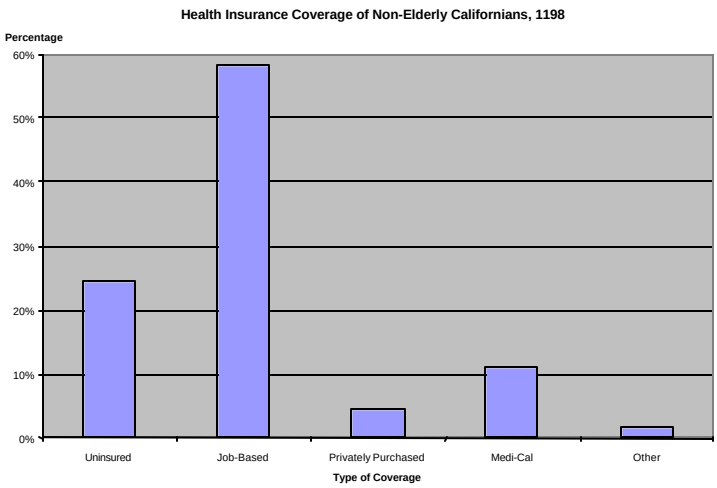
Public Discussion of Coverage Options. The California State Library will organize and conduct the policy option symposia to provide a forum for experts, stakeholders, and other members of the public to critically examine and provide input to the options and analyses.

Project Reports. The project will produce reports to HRSA and the State legislature.

Ongoing Public Participation at All Stages of the Process. Various mechanisms will be used to obtain stakeholder participation, including public review and comment on key documents, and participation of stakeholders in the policy option symposia. The size and diversity of California makes examining the State's uninsured and subsequent reform solutions relevant to the development of federal health reform solutions. California holds one-sixth of the nation's uninsured. In addition, the State's diversity provides a unique opportunity to examine several different issues and causes of the uninsured in one State Project. For example, the rate of the uninsured varies from county to county – ranging from 32 percent in Los Angeles to as low as 11 to 15 percent in some of the smaller counties -- with different types of barriers in each.

SECTION 1: CURRENT STATUS OF HEALTH INSURANCE COVERAGE IN CALIFORNIA

Access to Health Insurance Coverage in California



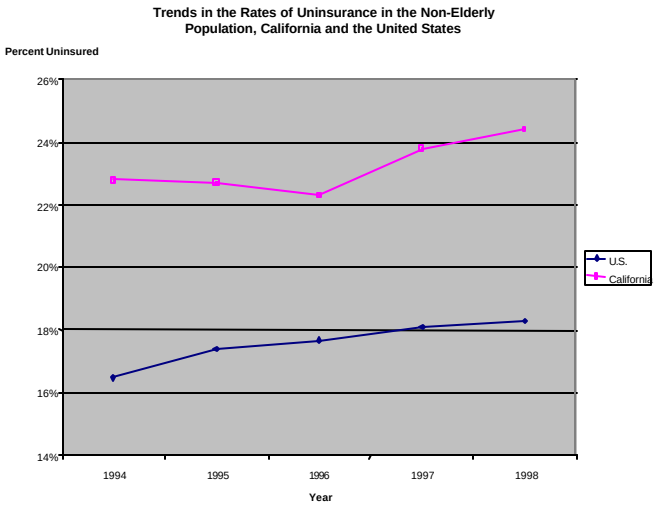
The majority of Californians, like U.S. residents nationwide, receive health insurance through their employers. As a result, the relatively low rate of employer-based coverage significantly affects the share of the population that is uninsured in California. In 1998, only 58 percent of Californians received health care through their employer, compared to 67 percent nationwide.

This difference is largely due to the fact that California businesses are significantly less likely to offer health benefits to their employees. Less than half of California businesses (48%) offer health benefits compared to 61 percent nationwide. In addition, a larger share of California's workforce (25%) is employed in very small (3-9 employees) and small businesses (10-50), which have the lowest health insurance rates. Small businesses in California with low-wage workers have particularly low rates of insurance. Of California's small businesses, in which a third of their workers earn low wages, 25 percent offer health benefits to their workers, compared to 38 percent nationwide. The percentage of Californians with employer-based coverage has remained virtually unchanged in the last few years.

Public programs in California have played a significant role in covering individuals who otherwise would be uninsured. Medi-Cal, the State's Medicaid program, covers a total of about five million Californians or about 15 percent of the State's total population. As the chart shows above, Medi-Cal covers 11 percent of the non-elderly population. California covers a higher percentage of its population under Medicaid than any other State.

California Medi-Cal enrollment did experience a drop between 1994 and 1998. The proportion of the non-elderly population covered by Medi-Cal declined by 3.2 percent compared to 1.6 percent in the U.S. However, Medi-Cal enrollment is no longer declining. In 1999, the enrollment rate remained virtually unchanged.

In 1998, California had 2 million uninsured children. The percentage of uninsured children is particularly problematic. Between 1995 and 1998, California's rate of uninsured children (ages 0-18) grew from 17 percent to 21 percent. By comparison, the nationwide rate of uninsured children remained constant at about 16 percent throughout the period.



Since 1998, California has made tremendous strides in children's coverage. In 1998, California began its Healthy Families program for children's health insurance. With an additional expansion in 1999, children with family incomes above Medi-Cal levels and up to 250 percent of poverty are eligible for coverage through Healthy Families. To date, Healthy Families has enrolled 300,000 children. However, lack of insurance is not only an issue of eligibility but also a problem with enrollment. Despite the impressive growth in enrollment since the program's inception, Healthy Families covers less than half of those children who are estimated to be eligible. Of the 2 million uninsured children in California, nearly three-fourths are eligible for coverage under either Medi-Cal or Healthy Families. (This is perhaps an overestimate due to an underreporting of Medi-Cal enrollment in the data set.) With recent expansions in the Medi-Cal and Healthy Families Programs, the current challenge is to find and enroll those children who are eligible. This will involve increased outreach and enrollment simplification.

Characteristics of the Uninsured

The high cost of health insurance has made coverage unaffordable for many Americans. Almost 60 percent of uninsured Californians cited the high cost of insurance as the major reason for not having coverage. Even when businesses offer health benefits, workers, particularly those with low incomes, are not able to afford their share of the premium. A greater share of California's population live in poverty -- 15.4 percent -- compared to 12.7 percent of the total U.S population.

In 1999, 40 percent of California's uninsured population have been without health insurance for at least the past five years. In general, people who are at the greatest risk of being uninsured are:

- people with low incomes,
- people from families with only part-time workers, workers in low paying jobs or small businesses,
- racial and ethnic minorities, particularly Latinos, and
- younger adults, particularly men.

Over two-thirds (69%) of uninsured Californians have family incomes less than 200 percent of poverty, which is about $33,000 for a family of four.

The vast majority of the uninsured in California is in working families (82%), and 47 percent are in families headed by at least one full-time, full-year employee.

Of ethnic groups in California, Latinos are most likely to be uninsured (40%). Over one-third of Latinos were never insured. Asian-Pacific Islanders and African-Americans had similar proportions of uninsured, 23 percent and 22 percent. The percent of uninsured white non-Latinos is 15 percent. Compared to the total U.S. population, California has a much higher proportion of Latinos (30.3% vs. 11.7%) and of Asian Americans (12.2% vs. 3.9%).

California has the highest percentage of non-citizens of all the States (15.8%). An increasing number of non-citizens in California are uninsured: 50 percent in 1998, up from 44 percent in 1995. The rate of job-based insurance for non-citizens is even lower than other Californians.

Of California's young adults (ages 18 to 29), 39 percent are uninsured. Young adults who are in school or new to the labor market have lower rates of job-based insurance than other age groups. Californians between the ages of 40 and 54, on the other hand, show higher rates of coverage.

Key Health Issues Related to Access and Uninsurance

Being uninsured has critical implications for health. Uninsured populations often do not seek medical care because of cost, have reduced access to preventive care and health promotion activities, and have poorer health status in general. Data from the California Behavioral Risk Factor Survey in 1999 shows that 34 percent of the uninsured did not seek health care when they needed it due to concerns about the cost of care. The insured population had significantly lower rates of failure to seek care, regardless of their types of insurance. The reduced access to preventive care of California's uninsured is evidenced by the California Behavioral Risk Factor Survey's finding that in every clinical service examined, uninsured adults had lower rates of receiving the service than insured adults. As with preventive care, uninsured adults are also less likely than insured populations to have access to and participate in health promotion programs (9% vs. 15%). Health status of the uninsured in California is not perceived to be as good as that of the insured population. Uninsured adults are more than twice as likely as insured adults to report their health as being fair or poor.

A larger portion of the insured population uses a doctor's office as their regular source of care (58% compared to 40% of the uninsured population), and while 16 percent of the uninsured population use a hospital emergency room as their usual source of care, only 4 percent of the insured population do.

California's Health Care Coverage and Delivery System

Managed care is a strategy that controls costs and utilization and places an emphasis on preventive and primary care to improve health outcomes and make care more cost-effective. California released its strategic plan to transition its Medi-Cal program to managed care in 1993. Currently, the penetration of managed care is substantially higher in California than in the country at large, with 52 percent of Californians enrolled in HMOs in 1999, compared to 30 percent nationwide. Three-fourths (74%) of insured, non-elderly Californians are enrolled in a private HMO or PPO plan. Holders of private indemnity health insurance comprise less than 2 percent of the population. The remaining quarter of the insured population receive their insurance coverage through publicly-sponsored programs like Medi-Cal and the Healthy Families Program.

Medicare HMO enrollment has grown to 40.2 percent of beneficiaries. Medicaid HMO enrollment has reached 46.6 percent of beneficiaries. Incremental expansion of coverage within publicly-sponsored programs has been one of California's central strategies for lowering the number of the uninsured.

A larger percentage of Californians are enrolled in non-profit HMOs than in the rest of the country. Though Kaiser Foundation Health Plan is a non-profit HMO, it holds the largest market share of the top five plans. Despite the fact that across the United States enrollment in non-profit HMOs declined during the period from 1995 to 1998, from 42 percent to 37 percent, the proportion of Californians enrolled in non-profit HMOs has remained fairly static, at about 43 percent.

California's Health Delivery System

Hospitals in California are 28 percent for-profit, 23 percent government-owned, and 49 percent non-profit, according to 1998 data from the Health Research Educational Trust. California has a significantly higher percentage of for-profit hospitals than the country as a whole, and fewer government-owned hospitals. Perhaps contributing to this conversion is the trend in lowered rates of hospitalization and a greater emphasis on outpatient care. As a result, the number of hospital beds in California has declined to 277 per 100,000 individuals in 1998.

In 1996, 198 of California's hospitals were for-profit and 201 were non-profit. The remainder were owned by districts (61), cities/counties (44), Kaiser (32), churches (53), and the University of California system (8). At that time, the 30 hospitals that make up the core of California's essential safety net provider community provided over $1.3 billion of hospital care to the medically indigent and uninsured populations, care that comprised approximately 29 percent of these hospitals' total operating expenses. These 30 core safety net providers make up only 6 percent of all hospitals Statewide, but provided almost 40 percent of all inpatient care to the uninsured and medically indigent in California. The growing rate of the uninsured places increasing pressure on these safety net providers and affects their financial viability.

The number of physicians per 100,000 residents in California remained relatively stable from 1990 to 1997, with a 1997 ratio (the most recent data available) of 278 per 100,000. Though the ratio for the United States grew more over the period (from 237 to 276 per 100,000 residents), its 1997 ratio was very close to California's 1997 ratio.

Sources

Brown, E. Richard. "California's Growing Uninsured Population and Options to Expand Coverage." UCLA Center for Health Policy Research. May, 2000. (http://www.healthpolicy.ucla.edu/)

HIPP Policy Alert, "What Accounts for California's Low Employment Based Coverage." May 2000

Schauffler, H.H. and Brown, E. R. "The State of Health Insurance in California, 1999." Health Insurance Policy Program, January 2000.

California HealthCare Foundation. "Employer-Sponsored Health Insurance: A Survey of Small Employers in California." August 1999.

Schauffler, H.H. and Brown, E. R. "The State of Health Insurance in California, 1999." Health Insurance Policy Program, January 2000,

The Kaiser Commission on Medicaid and the Uninsured. "The Uninsured in America: A Chartbook." June 1998. .

The Kaiser Family Foundation. “Health Care Trends and Indicators in California and the United States.” June, 2000, “The Interstudy HMO Industry Report.” April 2000.
"California Health Care Factbook, 1999". California Office of Statewide Health Planning and Development.
California Association of Public Hospitals and Health Systems. “California’s Uninsured and the Future of Open Door Providers” April 1999.
Institute of Medicine. “America’s Health Care Safety Net: Intact but Endangered.”

SECTION 2: EARLIER EFFORTS TO REDUCE THE NUMBER OF UNINSURED RESIDENTS

In reaction to the increase of the uninsured in California the 1990's, the State has implemented many reform measures to reduce the number of uninsured. The legislative proposals have ranged from expanding existing public insurance programs and creating new programs that target selected populations, to reforming the insurance market and targeting small businesses with employer coverage options. Health care has been an important issue in California's legislative history, including several bills intending to insure universal coverage through a variety of mechanisms. Although it failed, Prop 186 was proposed to establish a single-payer Canadian style health care system in California and establish the State as the insurer of health care benefits for all Californians.

The State has had a long history in providing support for care and treatment of the low-income uninsured. State law provides that counties have a responsibility to provide care for the indigent. The State shared some of this responsibility when it extended Medi-Cal coverage to the medically indigent beyond the categories mandated by federal law. In 1982, responsibility for the indigent was returned to the counties with substantial financial support from the State. In the 1980s the State passed the groundbreaking Proposition 99 that provided substantial support for indigent care through revenue received from a special tax on tobacco products. In 1991, the State restructured funding for certain health care services provided by counties and allocated a specified portion of tax revenue to local health care needs. Currently, these tax revenues provide $2.4 billion for those activities.

Recent Legislative and Administration Efforts

Governor Davis signed a fiscal year 1999-2000 budget and accompanying legislation that authorized a 4.8 percent increase in spending on health and social services. The budget provided for significant expansions of Healthy Families and Medi-Cal as well as elimination of administrative barriers related to the application and re-determination processes. For example, to reach the uninsured children who are eligible for Healthy Families and Medi-Cal, the Department of Health Services and the Managed Risk Medical Insurance Board were required to develop options for streamlining eligibility determination processes. As part of the 1999-2000 budget, the eligibility income limit for families was increased to 100 percent of the FPL and categorical restrictions for parents were removed, allowing an estimated 250,000 parents to become Medi-Cal eligible. The State implemented the federal option for disabled workers, which allows disabled workers to pay premiums based upon their income to buy into the Medi-Cal program. Medi-Cal also allows mail-in applications.

In May 2000, the Governor offered a revised budget proposal for 2000-2001 that included $1 billion to expand access to health care for the poor. In the 2000-2001 budget, that was recently enacted, additional steps were taken to expand health coverage in California. The budget includes expansion of outreach efforts to enroll children in the Healthy Families and Medi-Cal programs. It provided funds sufficient to enroll by the end of the year almost all children eligible for Healthy Families. It also eliminates quarterly status reports for Medi-Cal families, decreasing an administrative barrier to continuity in coverage. In addition, it increases income

eligibility limits for the aged and disabled to 133 percent of the poverty level and continues Medi-Cal for older adolescents (ages 18 to 21) when they leave foster care.

Additionally, Governor Davis approved a $5 million boost for the State's $40 million Major Risk Medical Insurance program (MRMIP) that helps individuals who have been denied health insurance due to pre-existing conditions to secure coverage. The increase is sufficient to maintain the current number of insurance slots available and may provide insurance for many of the 4,600 people who are waiting for coverage under MRMIP.

In 1999, the Legislature passed and the Governor signed SB 480 to address the goal of universal coverage in California. The bill calls upon the Secretary of the California Health and Human Services Agency to develop a public process to examine and analyze various universal coverage reform approaches. This bill was intended to build on previous work to examine reform options and methodologies that included wide ranging discussions among consumers, government and technical advisors and model development experts. SB 480 requires the Secretary to report to the Legislature by December 1, 2001 concerning options for achieving universal health care coverage and the process to develop these options.

State Public Insurance Programs

California is both a payer and a regulator of health care by using a multiplicity of disconnected programs and revenue streams to pay for care. In 1990, the Managed Risk Medical Insurance Board (MRMIB) was created with a broad mandate to advise the Governor and the Legislature on strategies for reducing the number of uninsured persons in the State. MRMIB currently administers three health care programs: Major Risk Medical Insurance Program (MRMIP) for uninsurable adults; Access for Infants and Mothers (AIM) for uninsured pregnant women, and recently the Healthy Families Program (HFP) for children in low wage families.

MRMIP was developed to provide health insurance for Californians who are unable to obtain coverage on the open market, primarily due to severe health conditions. The program supplements the health insurance premiums for qualifying medically uninsured Californians who are rejected by commercial carriers in the individual health insurance market. The typical subscriber is a woman between the ages of 40 to 59 with a pre-existing condition. MRMIP has served nearly 75,000 persons since it opened in 1991 and services in the program are delivered through contracts with 6 health insurance plans. MRMIP is also funded by $40 million from tobacco tax funds.

AIM is part of California's efforts to increase health coverage of pregnant women and their newborns up to 2 years of age. The program offers subsidized premium health coverage to moderate-income pregnant women and their infants. The average subscriber is a married woman, living in a household with a family income between 200 to 300 percent of FPL. Since 1992, AIM has served nearly 42,000 pregnant women and their infants.

In addition to the MRMIB programs, the Department of Health Services offers many programs that provide health coverage to the otherwise uninsured. The Genetically Handicapped Persons Program was created for uninsured/uninsurable adults with certain qualifying congenital

conditions with no maximum income eligibility standards. It also covers some children whose income exceeds eligibility requirements for California Children's Services (CCS). Approximately 1,800 persons are currently served. There are no co-payments for the program. Families with higher incomes pay an enrollment fee based on a sliding fee schedule for family size and income.

State and Federal Public Insurance Programs

With the federal enactment of State Children's Health Insurance Program in 1997, the State created the Healthy Families Program for children with incomes up to 200 percent of FPL (raised to 250 percent in 1999) and expanded Medi-Cal to children ages 6-18 with incomes up to 100 percent of FPL. The Healthy Families Program provides comprehensive low cost health, dental and vision coverage to children in low wage families. Families participating in the program choose their health, dental and vision plan. Families pay premiums of $4-$9 per child per month (maximum of $27 per family) to participate in the program.

Medi-Cal, with 5.1 million California beneficiaries, provides health insurance coverage for over 50 percent of the poor and 20 percent of the near poor, including pregnant women and infants with family incomes of up to 200 percent of FPL. The program pays for almost 50 percent of all births in the State.

Two child-only programs include California Children's Services (CCS) and Child Health Disability Prevention Program (CHDP). CCS provides children with CCS eligible chronic or severe illness conditions ages 0-21 with diagnostic evaluations, treatment services, medical case management and medical therapy services. Approximately 147,000 children are served. CHDP provides periodic preventative health services and assessments, immunizations, and dental services to Medi-Cal beneficiaries ages 0-21 and other children 0-19 in families with incomes up to 200 percent of the federal poverty level. Current target population is 4,832,000 children. State, county and federal funds combine to finance these programs. State and county funds cover only about 25 percent of children in each program.

Health Insurance Market Reform

Insurance market reform in California has taken the form of enabling legislation to encourage innovations through group purchasing, reform of small group and individual market insurance products and extending coverage under COBRA. AB 1672, "small group reform," enacted by California in 1992, strengthened provisions to ensure employers have an option for health insurance and to protect individuals with preexisting conditions. Guaranteed issue and renewal and preexisting condition provisions in California conform to HIPAA for small employers with 2-50 employees (amended 1996) regardless of the group's industry or risk status. The small group rules also put limitations on the premiums that can be charged. Preexisting conditions are defined as conditions for which medical care was recommended or received six months prior to the issuance of the policy.

AB 1672 also established the Health Insurance Plan of California (HIPC), a national pre-eminent small employer purchasing pool. HIPC gives small employers (2-50 employees) real purchasing

clout since they come together as one big group. Consequently, the small employers can give their employees a broader and more affordable choice of health, dental and vision plans.

Under Cal-COBRA, California has extended federal COBRA principles to smaller firms. Employees are responsible for up to 102 percent of employer premium costs. Firms with fewer than 20 employees must permit departing employees to continue group coverage for up to 18 months (36 months for dependents). To address the gap between the end of COBRA coverage and eligibility for Medicare at age 65, employers are required to continue COBRA coverage past the traditional 18 months at somewhat higher rates for employees older than age 60 with at least five years tenure.

Private Sector Efforts

California Kids, a project of Blue Cross of California prior to its conversion to for-profit status, is a $4 million program for 10,000 primarily undocumented children. It is fully subsidized at no cost to the children or their parents.

Kaiser Permanente Cares for Kids Child Health Plan is a five-year initiative for uninsured children not eligible for Healthy Families Program or Medi-Cal. KP has committed $100 million to this effort. Components of the program include subsidized health coverage for up to 50,000 children annually; partnerships with schools and PacAdvantage to enroll and subsidize health insurance for children and participate in legislative and research efforts to develop solutions for uninsured children in California.

Since California approved cross-border health coverage earlier this year, two employer-funded HMOs, Tijuana- based Servicios Medicos Nacionales SA and San Francisco-based Blue Shield of California Access Baja HMO, now offer plans that cover both Mexican and U.S. health care systems. In San Diego and Imperial counties, the plans could help 50,000 workers and their families, who were ineligible for coverage in Mexico's social security system but barred from U.S. HMOs.

The Successes and Implementation Problems of Earlier Efforts

Although new and expanded programs increase the number of people eligible for public insurance, it also results in fragmentation. The numerous programs can create a navigational challenge for applicants. Therefore, many are not aware that they are eligible. For others, the complexity causes them not to apply, although they are eligible. For ethnic communities, reluctance to enroll may be related to fears of public charge.

Between 1995 and 1998, Medi-Cal enrollment has declined. A recent Families USA report found that between January 1996 and December 1999, California had a 19 percent drop in enrollment of adults. Although the decline was significant, it was the second lowest of the 15 States in the survey, much less than the 27 percent decline for all 15 States in the survey. The decline in California occurred before January 1, 1998, the date federal welfare reform was implemented in California. Between January 1998 and December 1999, California had a very slight increase in adult enrollment. California has not yet experienced the impact of the Medi-Cal expansions that

went into effect in March 2000 and of the mail-in application, as well as the elimination of the quarterly status report, effective on January 1, 2001.

Nonetheless, there are a significant number of people who are eligible but are not enrolled in Medi-Cal as well as other public insurance programs. About three-fourths of the uninsured children are eligible but not enrolled in insurance programs. Despite recent efforts to simplify the enrollment process and increase awareness of the programs, streamlining enrollment processes is an ongoing challenge. In particular, the State continues to examine opportunities to ensure continued Medi-Cal enrollment for those families who leave CalWorks and yet remain eligible for Medi-Cal.

Despite the efforts of small employer market reforms, less than half of small firms (2 to 50 employees) in California offer their employees health insurance benefits. Cost is cited as the primary barrier. Less than one-third of small employers are aware of their purchasing options through PacAdvantage. The lower than expected enrollment in PacAdvantage (or HIPC) may also be due to the lack of subsidies to small businesses to purchase insurance for their employees through the program. Limited funding for MRMIP means that it is not accessible to most Californians who have been denied private insurance coverage because of preexisting conditions. Furthermore, the MRMIP pool constitutes a sicker population, resulting in higher premiums.

Existing programs do not cover everyone who is uninsured, namely single adults, childless couples and low-income parents. In particular, the State's immigrant population accounts for a disproportionate share of the uninsured.

How the Project will Help to Support these Earlier Efforts or Create New Initiatives

The HRSA planning grant provides California the opportunity to synthesize the rich research from multiple sources that are currently available on the issue and use it as a platform to inform a comprehensive analyses of reform options specific to California. Most importantly, it provides the opportunity to fully implement SB 480, a State mandate to develop a much-needed public dialogue on the specific features of various reform options and implications of these approaches. Public participation is an essential ingredient to advancing an array of reform options for the consideration of policy makers to achieving universal health coverage in California.

Sources

Methodological and Modeling Assumptions in the California Universal Health Insurance Coverage Study Proposal. California Policy Research Center- UC. Executive Summary

http://www.cbp.org/qhits/qh000405.html (California Budget Project Quickhit)

Schauffler, H.H. and Brown, E. R. UCLA Center for Health Policy Research. "The Uninsured in California: Causes, Consequences and Solutions, 1997."

R. Cronick, T. Gilmer, et. al. "Expansion of Health care to the Working Poor. 1999." California Research Policy Center

Schauffler, H.H. and Brown, E. R. "The State of Health Insurance in California, 1999." Health Insurance Policy Program, January 2000.

Klein, Rachel and Zeldin, Cindy. "Go Directly to Work, Do Not Collect Health Insurance," Families USA Foundation, June 2000.

SECTION 3: REQUESTING PREFERENCES

California requests consideration as a State with the ability and commitment to significantly decrease a high rate of uninsured.

Lack of insurance is a great impediment to the health and well being of many Californians. In 1998, the number of uninsured Californians reached 7.3 million, 24 percent of the population. The rate of uninsurance is substantially higher than the rest of the United States whose uninsured comprise 17 percent of the population.

A number of confounding factors contribute to California's high number of uninsured. California's low rate of employer-based coverage is frequently cited as major factor, as are barriers to public insurance programs. Less than half of California businesses provide health coverage compared to 61 percent nationwide. California has a disproportionate share of small businesses, which are less likely to offer health benefits to their employees. A majority of the uninsured, 85,percent are in low-income working families and 75 percent are poor or near poor. Many in this population, including about 1.5 million uninsured children, are eligible for public insurance programs, but not enrolled.

The size and diversity of California's population and the complexity of its health care system create significant challenges for policy makers trying to address the problem of the uninsured. Despite recent market reforms, expansions of public insurance programs, and policies to reduce the barriers to health coverage, the number of uninsured Californians continues to grow. While providing coverage for thousands of Californians, previous efforts have not attempted to eliminate the problem of the uninsured as a whole. In passing SB 480 (Solis), Chapter 990 Statutes of 1999, the Governor and the Legislature have acknowledged that a comprehensive and public evaluation and discussion of approaches to universal health care coverage is critical for policy makers to advance health reform solutions for implementation. The SB 480 legislation and this Health Care Options Project emphasize stakeholder participation in reform development because past experience with health reform at the State and federal level have demonstrated that public participation is necessary for reform advancement. Entrenched and opposing perspectives require that all viable options be thoroughly vetted before policy makers can legislate reform.

The State Planning Grant will provide critical assistance to CHHS in engaging public and private sector stakeholders in a more comprehensive and analytic initiative than would otherwise be possible.

SECTION 4: STATEMENT OF PROJECT GOALS

The goal of the California HCOP is to investigate a broad range of alternatives for achieving universal health coverage in California. This project will complement the planning process that California has underway pursuant to recent legislation (SB 480). Specifically, the Project will examine the following issues:

- What is the range of viable strategies for attaining universal health coverage based on the specific issues in California?
- How can these strategies be financed?
- What are the institutional changes that would occur with each alternative approach for achieving universal health coverage?
- What effects would we expect on benefit levels, access, quality, range of services, reliance on preventive care, and the stakeholders?

The proposed HRSA planning grant will build on the support and resources already identified for California's SB 480 process. Additional support from HRSA grant funds will enable the State to undertake thorough analysis of each of the proposed alternative approaches to universal coverage. The Project's careful and detailed design for public discussion will provide the sound basis for developing the specific features of each reform option. The HCOP process will produce a comparative analysis of these alternatives and develop a public record of debate regarding the validity of the analysis and the values inherent in the conclusions drawn. This public review of the alternative will be an invaluable contribution to any future legislative discussions of health coverage.

Key components of the proposed project include:

- Literature reviews and background papers on research into factors affecting the uninsured in California and on research into alternatives approaches to achieving universal health care coverage.
- Assessment of the effects of current proposals and identify gaps in those proposals that need to be addressed.
- Development and analysis a full range of alternatives in order to define workable models for California.
- Identification and inclusion public and private partners in discussions and development of alternatives and of implications of those alternatives for achieving universal health coverage.

The comprehensive investigation of alternatives described in this grant proposal has important implications for other States' projects. California is both more diverse and more reliant on public health coverage than most States; thus, the project may inform the nation about the range of challenges in achieving universal health coverage. In addition, our proposed intensive analytical effort can support other States' and federal planning processes. For instance, the reform options papers produced to inform California policy makers may be useful to other States in mapping out opportunities for increased coverage. Finally, California's overall process for analyzing and discussing these alternatives may prove a useful tool for other States.

SECTION 5: PROJECT DESCRIPTION

Introduction and Overview of the Proposed Approach

The California Health and Human Services Agency (CHHS) is submitting this proposal to the federal Health Resources and Services Administration to obtain funds to investigate options for achieving universal health coverage in California. In order to design and implement a project of appropriate and elaboration given the complexities in California, grant funds from HRSA are necessary to augment existing State resources. The HRSA State Planning Grant Program provides an opportunity for CHHS to further develop and implement a process that provide a framework for analysis and assessment of viable strategies for reducing the growing number of California's uninsured. Towards that end, this HRSA grant will enable CHHS to engage a broad cross-section of public and private sector stakeholders in a public discussion of the full range of universal health care coverage options.

The Health Care Options Project (HCOP) is designed to guide the State in a systematic exploration of different approaches to achieving universal coverage by engaging in an in-depth examination of a full range of reform options. These options will be quantitatively analyzed and reviewed through a public process. The results will be forwarded in a report to the State Legislature that will include contain the quantitative analysis and thorough discussion of various stakeholder perspectives. This intention of this report will be to provide policy makers and stakeholders with the necessary tools to use in future policy discussions and any future actions they may take aimed at reducing the current and growing uninsured population in the State.

The CHHS will lead this effort with the support of the California State Library. Other State departments participating in this effort include the Department of Health Services, the Department of Mental Health, the Department of Finance, the Managed Risk Medical Insurance Board, the Department of Consumer Affairs, the Public Employees' Retirement System, the Department of Social Services, the Department of Managed Care, and the Department of Insurance. Resources for this effort include State staff, consultants, commissioned researchers and a modeling contractor.

Key elements of the California project are:

- *Synthesis of Existing Data and Research.* CHHS will work in collaboration with the various State departments to identify and assure that existing data sources are made available for analytic efforts including development of options papers and modeling. CHHS will work in collaboration with the California State Library to support the development of literature reviews and background papers needed for the full exploration of selected policy options.

- *Develop and Analyze Coverage Options*. CHHS will commission health policy experts to prepare papers that develop and explore options for health coverage. The select options should represent the full range of alternative approaches. CHHS will also select a contractor to prepare a comparative quantitative analysis of the financial aspects of each proposed option as well as other impacts in a way that allows comparison across the range of options under consideration.

- *Public Discussion of Coverage Options*. The California State Library will organize and conduct the policy option symposia to provide a forum for experts, stakeholders, and other members of the public to critically examine in detail each alternative approach and provide comments and recommendations to further refine the options.

- *Project Reports*. The project will produce reports to HRSA and the State legislature that detail the analysis of the options and the results of the public debate over the relative merit of the alternatives.

- *Ongoing Public Participation at All Stages of the Process*. Various mechanisms will be used to obtain stakeholder and technical expert participation including a Technical Advisory Committee, public processes to review key documents, and participation of stakeholders in the policy option symposia that will explore potential options for California.

The Governor signed SB 480 in the fall of 1999, which requires an examination of options for achieving universal coverage in California. SB 480 calls upon the Secretary of Health and Human Services Agency to investigate options for achieving universal health coverage, in particular, a process that involves various stakeholder groups, as well as State departments and agency representatives. The Secretary is required to submit a report on the process to the Legislature by December 1, 2001. This Project has been slow in getting started due to lack of funds and other resources.

A. Detailed Project Narrative

The Project will be led by CHHS with the support of the California State Library. Independent technical review and guidance will be provided by a Technical Advisory Committee comprised of recognized health policy and research experts. In addition, stakeholders will review initial requests for proposals for reform options and for the analytic modeling contract, as well as provide extensive discussion and input into the reform options through public forums. Stakeholders will include, among others, representatives of providers, associations, insurers and health plans, consumers, businesses, labor, as well as legislative and State and county department staff.

The State proposes a series of activities including:

1) Synthesis and collection of existing data and research,
2) Identification and facilitated access to existing CHHS data sources;
3) Development of model and reform option papers including an extensive RFA design process;
4) Public discussion of the range of healthcare coverage approaches;
5) Ongoing public input at all stages of the process and
6) Final project reports which capture the comparative analysis of the reform options and the perspectives of the various stakeholders.

Synthesis of Existing Data and Research

CHHS proposes several data collection activities to ensure the project benefits from the latest research, databases and analysis reflecting California's unique demographic, utilization patterns and policy and regulatory implications. First, CRB will synthesize current reports and existing data into a series of briefing papers that will be provided to potential option authors, modeling contractors and stakeholders. These reform options papers will provide a framework for the development of the option papers and modeling. California has a relative rich set of studies, surveys, and other analyses that have defined many aspects of the uninsured population. This work provides a solid basis for the development of reform options as proposed. Second, CHHS and CRB (Project Management Team) will identify and facilitate access to the databases that will be most relevant to reform option authors and the modeling contractor the development of the options papers and quantitative analyses. The Project Management Team will develop a coordinated approach that will allow these data sources to be easily accessed for the analytical work; and conduct of any additional required data collection activities identified by HRSA for all planning grantees.

Data Sources Potentially Available for this Project

The CHHS, and its departments, can facilitate access to a variety of State administrative databases. The databases potentially available include: hospital and other health facility financial, encounter and utilization, and patient data, Medicaid Eligibility Determination System (MEDS) data, and Healthy Families (SCHIP) databases.

Because California is such a large State, several federally or privately funded surveys provide usable sample sizes for California. The most comprehensive national survey available for this project is the 1996-97 Medical Expenditures Panel Survey (MEPS), which provides health insurance and expenditure data combined with individual and household demographic data. In addition, Census Bureau surveys such as the Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP) provide demographic, economic, employment, and health insurance coverage information. Further, several special surveys funded by Foundations contain potentiality useful California specific data for analysis. These include the California Work and Health Survey, which has limited longitudinal features, and the Kaiser Family Foundation survey of California employers provides information on employment-related insurance.

Other data analysis and collection resources supported, in part, by the State may be available for use in this project. For example, the California Census Research Data Center has the ability to match State administrative or other survey data with Census Bureau surveys for use by researchers. Currently, a research team has approval to match California's MEDS file with CPS and SIPP survey data to perform analyses of well known undercounting of Medicaid and public assistance use as reported by those Census surveys.

California also is about to field a 39,000 household survey – the California Health Information Survey (CHIS). This survey will not have data in time for use during the life of this planning

grant, however, this survey would be available for use in subsequent activities. Finally, the Department of Health Services has some capacity to perform ad hoc telephone surveys.

Development of Reform Options and Analytic Modeling Contract

The Project Management Team will commission the development of universal coverage reform option papers. Each paper will outline the key components of the design approach as well as provide a qualitative analysis of the design. The range of selected papers will represent the full continuum of major reform options ranging from incremental reform that builds upon the wide array of existing programs in California to more comprehensive reform approaches that could include extensive reconfiguring of public spending and restructuring of existing public programs. The Project will commission about 8 to 10 papers to develop options for incremental reform approaches for market-based approaches, combined subsidy and market-based approaches and public funding restructuring approaches.

The Request for Proposal will outline the key features that each reform option paper should describe, such as the proposal's financing, type of mechanism, level of benefits, and cost-sharing elements. These features will also take into account some of the following variables: targeted expansion groups (e.g., parents of SCHIP children, young adults ages 19 - 20, early retirees), type of health care delivery system, administration, outreach, eligibility levels, eligibility determination process, enrollment process, marketing plan, coverage and benefits (similar to State, Federal employees, Medicaid, other credible coverage), portability, and integration with existing public and private programs, (e.g., Medicaid, Medicare and SCHIP coverage, and other State programs). The options papers also will provide a qualitative analysis of the access to preventive services, the quality of care, and implications for underserved populations and the health delivery system.

Based on the detailed options, the Project will commission a quantitative analysis through a micro-simulation model. The analytic model will compare the impacts of the various health reform options and provide a means to compare alternative approaches. The comparative analyses will project the level of insurance coverage produced by each option, overall costs, the financing and sources of revenue required, "winners and losers" by sector and subgroup of the population, and administrative costs. The analyses will generate these measurements in order to identify tradeoffs among the various options that provide varying levels of coverage, access and costs.

The model will measure some key implications for each reform option:

- who pays money into the system;
- what services are used, at what cost;
- how much would an option cost overall;
- who pays under each option;
- how many people would be covered; and
- what are the effects on those already insured (cost and benefits).

The Request for Application (RFA) for the modeling contract will specify key variables and parameters of analysis as well as identify key behavioral assumptions. Behavioral assumptions used for the model, such as how individuals, employers, other entities are assumed to react to changes in policy and circumstances, are significant determinants for the results of analyses. More importantly, many assumptions are generated from limited data. For this reason, CHHS will convene a Technical Advisory Committee (TAC) to guide development of the RFA and the work of the contractor in structuring the models that would be used to estimate the effects of each coverage strategy.

In developing the model contract RFA the Project Management Team will rely on the Review Team, and the recommendations and comments from the Technical Advisory Committee and stakeholders. The Review Team will consist of State staff from various agencies and departments, and Legislative staff. The Technical Advisory Committee will consist of technical experts in modeling and health policy research. Stakeholder groups such as consumers, providers, businesses, labor, and insurers and health plans will be consulted throughout the process. State staff will develop the RFAs for the model contract and the option papers and provide it to the Review Team, which will consult with TAC in refining the RFAs.

The Review Team will also examine and build upon the report and recommendations previously compiled by the Universal Health Care Technical Advisory Committee (UHCTAC) in California. The UHCTAC has already recommended key strategic approaches for resolving outstanding analytical and methodological issues. For example, UHCTAC found that an analytic model could quantify some basic measurements such as the level of insurance coverage. It also recommended an explicit focus on a variety of policy approaches, including those that do not necessarily aim for or guarantee universal coverage.

The model contractor would be required to present, at a minimum, the technical approach proposed to analyze behavioral responses and uncertainty in assumptions; and work with the authors of the reform options; identify data sources, both national and California-specific; specify any approach used to adjust for California-specific factors; provide references and examples of similar work. A Draft RFA will result from this process which will then be provided to stakeholders and the general public for review and comment. The Review Team, in consultation with the TAC and with comments and recommendations from stakeholders, will select the model contractor as well as the option paper proposals based on applications responding to the final RFAs.

The selected authors for the reform option papers and the model contractor will work closely to ensure that the papers include the key features needed for a comparative analysis. The Review Team, CRB, and the Technical Advisory Committee will be available to provide technical guidance, access to State databases and compilations of existing research. The result from this phase of the Project will be several draft reform options papers for review and discussion in a public forum. The model contractor will also provide comparative analyses of these draft options and additional support for the public discussion.

Conducting Public Symposia on Reform Options

The CRB and CAFIS, in coordination with the CHHS, will organize a series of interactive symposia to provide a forum for experts, stakeholders, State and county officials and other members of the public to critically examine and provide perspectives on the reform options and analyses. This forum for public dialogue is the key component for this Project: Stakeholder participation will identify the necessary features of the reform approaches from the various perspectives of those affected by the health coverage system. In addition, this public discussion among health policy experts, policy makers and stakeholders will reveal both the quantitative tradeoffs and qualitative implications of the varying reform approaches. For example, a quantitative comparison will show which reform features could generate the greatest expansion in coverage relative to the financing mechanism, and at what level of benefits and out of pocket costs. The qualitative implications and stakeholder perspectives provide insight into how reform features will affect stakeholder behavior, access to health care and the health care delivery system itself. Finally, a public dialogue of the various reform options is the key component to moving reform options into State policy and implementation. Although the public dialogue will not likely yield a consensus, it might reveal some key features and priorities that any State policy for universal coverage in California would need to incorporate.

The Project envisions a series of five symposia. Stakeholders, as well as key health policy experts and legislative and Administration staff, will participate in discussion roundtables at these public symposia. At each of the first four symposia, several authors will present their draft reform options for coverage, with one or two reform approaches selected for each symposium. Included in these presentations will be the preliminary findings of the quantitative analysis, prepared by the modeling contractor. These presentations will be followed by a roundtable panel discussion of the features of the reform options and their implications. This discussion in turn will be followed by an interactive discussion with participants in the audience at large. These discussions will provide direct feedback on the draft reform options that may result in substantive modifications to the final reform options.

The Project Management Team and the California State Library will work with the authors to make any revisions necessary to the reform options based on the panel discussions. The model contractor will complete the comparative analysis of the revised reform options. With these papers and comparative analyses, CRB and subcontractors will compile the full analysis to be presented at the last symposium. This final symposium will be a critical step in developing the report on reform options, analyses and processes that will be sent to the Legislature. Throughout the process, CRB will widely disseminate the background research papers, draft reform option papers, preliminary comparative analysis, and compilation of the final options, analyses and discussion.

Project Reports

The Project Management Team will develop two reports summarizing the outcomes of the HCOP:

- A report to HRSA by September 30, 2001 that describes options for universal health care in California. Timing of the development options will require this report to include the work on reform options prior to conducting all of the symposia.
- A final report to the State Legislature and HRSA that will be developed after the end of the HRSA planning grant. This report will consist of a synthesis of prior work, a descriptive overview of each option, results of the modeling efforts, and other analysis, and stakeholder input fully reflecting the results of the symposia. It will also include a comparative analysis of all of the approaches including matrices that compare the features of each option.

B. Project Management Matrix

The following matrix summarizes the tasks to be implemented including: action steps, assigned responsibility, collaboration involved in the task, and the timetable. The matrix includes tasks that are already in process as well as those tasks that will continue after the 12 month planning grant. The pre-grant activities reflect the planning and organization tasks necessary to move rapidly into the data collection and analysis efforts. The post-grant activities reflect the efforts required to complete the report required under SB 480.

Task 1: Identify and Complete Necessary Pre-HRSA Grant Activities				
Action Steps	***Timetable***	***Responsible Agency or Person***	***Anticipated Results***	***Evaluation/ Measurement***
1: Identify Project Management Team and Project Coordinator	By 9/1/00	CHHS	List of members of Project Management Team and signed contract for Project Coordinator	Refer to Section 7: Evaluation Plan
2. Develop interagency agreements	By 9/1/00	CHHS and CRB	Multi-agency cooperation in project	Refer to Section 7: Evaluation Plan
3. Develop RFA for a Project Evaluator contractor	By 10/1/00	CHHS	Signed contract for Project Coordinator	Refer to Section 7: Evaluation Plan
4. Identify Technical Advisory Committee (TAC)	By 8/1/00	CHHS	List of members for TAC	Refer to Section 7: Evaluation Plan
5. Develop preliminary mailing list	By 9/1/00	CHHS, Project Coordinator, and Project Management Team.	Broad public awareness of project	Refer to Section 7: Evaluation Plan
6. Develop job descriptions	By 9/1/00	CHHS, Project Coordinator, and Project Management Team.	Strong project staff	Refer to Section 7: Evaluation Plan
Task 2: Develop and Implement Data Collection Efforts				
Action Steps	***Timetable***	***Responsible Agency or Person***	***Anticipated Results***	***Evaluation/ Measurement***

1.. Develop agreements & processes to access databases	By 10/1/00	Project Coordinator and Project Management Team.	Access to multi-agency databases	Refer to Section 7: Evaluation Plan
2. Provide ongoing data required by HRSA	10/01/00 through 9/30/01	CHHS	Fulfillment of grant requirement	Refer to Section 7: Evaluation Plan
3. Conduct literature reviews and syntheses for option papers	By 12/1/00	CRB	Summary of current research and analysis on approaches-	Refer to Section 7: Evaluation Plan
4. Print and disseminate background papers	By 1/15/01	CRB	Greater public awareness of issues and options. Baseline issue paper for authors of option papers and model contractor.	Refer to Section 7: Evaluation Plan
Task 3: Develop and Implement Analysis of Approaches				
Action Steps	***Timetable***	***Responsible Agency or Person***	***Anticipated Results***	***Evaluation/ Measurement***
1. Develop draft RFA for reform option papers	By 9/1/00	CHHS and Project ManagementTeam	Draft available for public comment and feedback from TAC and stakeholders	Refer to Section 7: Evaluation Plan
2. Develop draft RFA for modeling contractor	By 10/1/00	CHHS and Project Management Team	Identify specific products from modeling effort Draft available for public comment and feedback from TAC and stakeholders.	Refer to Section 7: Evaluation Plan
3. Disseminate draft RFA to TAC and stakeholders for review and comment	By 10/1/00	CHHS	Receive comments on draft RFAs	Refer to Section 7: Evaluation Plan
4. Refine RFA for reform option papers considering TAC and stakeholder recommendations.	By 10/1/00	CHHS, Project Management Team, and review team	Finalized RFA for Option Papers.	Refer to Section 7: Evaluation Plan
5. Refine RFA for model contractor considering TAC and STAKEHOLDER recommendations.	By 11/1/00	CHHS, review team, and TAC sub-committee	Finalized RFA for Model Contractor.	Refer to Section 7: Evaluation Plan
6. Release of RFA for reform option papers	By 11/1/00	CHHS and Project Management Team	Public release of RFA	Refer to Section 7: Evaluation Plan
7. Release of RFA for modeling contractor	11/1/00	CHHS and Project Management Team	Public release of RFA	Refer to Section 7: Evaluation Plan
8. Response deadline to Option Papers' RFA.	12/1/00	CHHS and Project Management Team	Receive responses to Option Papers RFA.	Refer to Section 7: Evaluation Plan
9. Response deadline to Model Contractor RFA.	12/1/00	CHHS and Project Management Team	Receive responses to Model Contractor RFA.	Refer to Section 7: Evaluation Plan

10. Review & select option paper authors considering TAC and stakeholder recommendations.	By 1/8/01	CHHS, Project Management Team, and Review team	Sign contracts for development of reform option papers.	Refer to Section 7: Evaluation Plan
11. Review and select modeling contractor considering TAC and stakeholder recommendations.	By 1/8/01	CHHS, Project Management Team, and Review team, .	Sign contract for modeling activities	Refer to Section 7: Evaluation Plan
12. Develop preliminary option papers, seeking technical assistance from TAC and model contractor as needed.	1/8/01 through 3/31/01	Selected authors	Development of preliminary options papers.	Refer to Section 7: Evaluation Plan
13. Submission deadline for preliminary option papers and model.	4/1/01	CHHS and Project Management Team	Receive preliminary Option Papers.	Refer to Section 7: Evaluation Plan
14. Disseminate preliminary options papers for review and comment	4/1/01	CHHS and Project Management Team	Opportunity for review and comment by interested parties.	Refer to Section 7: Evaluation Plan
15. Review option papers and evaluate options with model.	By 6/1/01	CHHS, Project Management Team and Model Contractor	Ensuring papers provides sufficient detail	Refer to Section 7: Evaluation Plan
16. Option papers refined, considering TAC and stakeholder recommendations.	By 7/1/01	CHHS and Project Management Team	Ensuring that that reflects best assumptions for California	Refer to Section 7: Evaluation Plan
17. Select papers for symposia	By 7 /1/01	CHHS and Project Management Team	List of reform options to be investigated further	Refer to Section 7: Evaluation Plan
18. Prepare and disseminate draft option papers and preliminary quantitative analysis in preparation for symposia.	By 7./1/01	CHHS, Project Management Team and CRB	Post option papers and analysis on website and mail to interested parties	Refer to Section 7: Evaluation Plan
Task 4: Develop, Present and Discuss Options				
Action Steps	*Timetable*	*Responsible Agency or Person*	*Anticipated Results*	*Evaluation/ Measurement*
1. Develop overall stakeholder strategy	By 9/1/00	CHHS, Project Management Team and CRB	Identification of stakeholder and public outreach activities	Refer to Section 7: Evaluation Plan
2. Develop and publicize website	By 10/1/00	CHHS, CRB, Project Management Team and contractor	Open site with all available documents	Refer to Section 7: Evaluation Plan
3. Develop schedule for symposia	By 2/1/01	CRB	Schedule and location for symposia	Refer to Section 7: Evaluation Plan
4. Identify mailing lists/invitees; organize logistics for symposia.	By 3/1/01	CRB and contractor as needed	Ensure broad contact with all interested parties	Refer to Section 7: Evaluation Plan

5. Disseminate reform option papers and preliminary quantitative analysis.	3 weeks prior to each symposia	CRB and contractor	Post papers on website and mail to interested parties	Refer to Section 7: Evaluation Plan
6. Conduct 5 symposia	By 12 /1/01	CRB and contractor	Conduct 4 sessions on reform options and final comparative session	Refer to Section 7: Evaluation Plan
7. Analysis from symposia incorporated into option papers and evaluated by model.	By 1/1/02	CRB, contractor Option authors, and model contractor.	Finalize option papers based on analysis from symposia.	
8. Prepare and disseminate report of symposia, including finalized options papers and final quantitative analysis.	By 3 /1/02	CRB and contractor	Provide summary of discussion and feedback collected at symposia	Refer to Section 7: Evaluation Plan
Task 5: Produce Final Reports				
Action Steps	***Timetable***	***Responsible Agency or Person***	***Anticipated Results***	***Evaluation/ Measurement***
1. Prepare and submit HRSA report on reform options and analysis.	By 10/1/01	CHHS, CRB, and Project Management Team	Meet HRSA report requirement.	Refer to Section 7: Evaluation Plan
2. Prepare and submit status report to Legislature.	By 11/30/01	CHHS, CRB and Project Management Team	Meet SB480 report requirement.	Refer to Section 7: Evaluation Plan
3. Provide final report on options, model estimates, and results of public discussions	3/1/02	CHHS, CRB and Project Management Team		

C. Governance

Management, accounting, and governance structure

The project will be conducted through a management and advisory structure that will enable efficient performance and completion of specific project tasks, as well as adequate public involvement and stakeholder input.

Project Accountability and Responsibility: Under the direction of Secretary Grantland Johnson, the California Health and Human Services Agency oversees policy for almost all of the State-level departments and programs affecting healthcare in California, including, among others, the Department of Health Services, Office of Statewide Health Planning and Development, the Managed Risk Medical Insurance Board, the Department of Social Services, and the Department of Aging.

The California Health and Human Service Agency (CHHS) will be overall manager of the project. Senior staff of the California Health and Human Service Agency (CHHS) will manage the project and have ultimate responsibility and accountability for complying with HRSA's requirements and all other project goals. The Agency will monitor grant expenditures and the budget for the project. The lead staff member at the Agency will be Kristen Testa, Assistant Secretary for Health. The Agency will work with other departments within State government including the Department of Managed Care, which is overseen by the Business, Housing and Transportation Agency, whenever necessary to complete the goals of the project, as well as the Department of Insurance and the State and Consumer Services Agency.

Staffing and Organizational Structure

Contractor and Project Management Team: A Project Management Team, consisting of staff from the California Health and Human Services Agency (CHHSA), the California Research Bureau and other State departments, as needed, will be established to perform and delegate specific project tasks. A contractor, overseen by the Assistant Secretary for Health, will coordinate day to day management of the Project and Project Management Team. The Contractor and Project Management Team will delegate tasks to staff in various State departments whenever specific skills or expertise is needed. Such tasks may include data compilation, review and analysis and Request for Application preparation and selection.

The Contractor and Project Management Team will occasionally seek guidance and feedback from a Review Team of representatives from Legislative staff, The Governor's Office, The Department of Finance, and other State departments. The Review Team and Project Management Team will make the selection to the options paper authors and model contractor in consultation with the Technical Advisory Committee. The Review Team will also consider the comments and recommendations provided by the stakeholders.

Role of California Research Bureau: The California Research Bureau (CRB) and the California Family Impact Seminar (CAFIS) will work in close collaboration with CHHS on several components of the project. Expert researchers and librarians within CRB will conduct comprehensive literature reviews, analyze current research and perspectives from experts in the field. They will also identify and develop databases for use by contractors and other project staff, and produce the background papers to be disseminated as part of the project. CRB will also provide additional research and analytical support as needed throughout the project.

The CAFIS project director and staff, working closely with CRB and CHHS, will oversee all aspects of the symposia, including the coordination of public outreach efforts, development and maintenance of a website for the project, compilation of a broad mailing and distribution list, and planning and implementation of the symposia themselves. Over its six-year tenure, CAFIS has developed expertise in planning and convening these types of educational symposia, with a reputation for non-partisan, research-focused presentations and discussions. CAFIS will also produce and disseminate the summary reports for each of the symposia.

Both CRB and CAFIS are part of the California State Library, headed by Dr. Kevin Starr. The Research Bureau provides original research and analysis to the legislative and executive

branches on a variety of policy issues. CAFIS is a joint project of the California State Library and the California State Library Foundation; it is supported by a combination of public funds and foundation support.

Technical Advisory Committee: The Technical Advisory Committee will be named by CHHS and will consist of experts in specific disciplines (i.e.: health policy and modeling) who will consult and provide feedback on various aspects of the project as needed. For example, the TAC will play an important role in developing specifications for the Request for Applications that must be prepared for soliciting coverage options papers and the modeling contract.

Stakeholder input will include representatives from the leading academic and research institutions, representatives for advocacy, providers, consumers, businesses, workers and health plans, and policy makers. Initially, stakeholders will be to provide input and review of draft products. Once options papers are developed, many stakeholders will serve as panelists at the symposia, where they will analyze make recommendations on coverage option papers.

Opportunities for Collaboration

The project offers significant opportunities for collaboration among State departments, foundations, advocacy groups and stakeholders, including health professionals, insurers and health plans, businesses and workers. Many California institutions in both the private and public sectors have focused on the problem of the lack of health coverage for Californians. Under the Davis Administration, significant program expansions have been enacted to increase access to publicly sponsored coverage for low-income persons. Private foundations and other health care organizations have offered coverage programs to allow low income persons access to basic coverage if they do not have employer based coverage. Broad-based coalitions have made efforts to adopt a Statewide basis universal coverage program. Groups representing health professionals and providers have been active in these efforts. However, not since 1990 have these and other interested parties joined together in exploring the range of options for expanding health coverage. This Project offers the opportunity for these disparate organizations with considerable knowledge and experience in the issues raised by expanding coverage in order to come to a common understanding of the primary options for broader coverage, the costs, the chances of achieving widespread participation, and the other qualitative aspects of the each proposed option.

Project Personnel: Staff Biographies and Responsibilities

California Health and Human Services Agency

David Maxwell-Jolly, Deputy Secretary for Program and Fiscal Affairs
From 1986 to 1999, Mr. Maxwell-Jolly served as the Principal Consultant to the California Senate Appropriations Committee. In that position, he analyzed the costs of pending health and human services legislation for committee members and other legislators; assisted the committee in establishing annual legislative priorities; negotiated the details of legislation under the jurisdiction of the committee with legislators, the executive branch, local government officials, and interest groups; and assisted in negotiating the health and welfare components of the annual State budget and preparing related implementing legislation. His major legislative efforts

include welfare reform legislation in 1993 and 1997, the Healthy Families health insurance program for children in 1997, the realignment of health and welfare programs in 1991, start-up funding for expansion of Medi-Cal managed care, the Medi-Cal capital funding program, and the disproportionate-share hospital payment program. Mr. Maxwell-Jolly has also worked as a supervising analyst with the Office of the Legislative Analyst, and as a project analyst with Kaiser-Permanente Medical Care Program.

The Health and Human Services Agency administers State and federal programs for health care, social services, public assistance, job training, and rehabilitation. Overseeing a budget of in excess of $55 billion in total funds, the Health and Human Services Agency comprises about 27 percent of the State's General Fund budget, the second largest General Fund component of the State budget behind K-12 education. The departments in the Agency employ in excess of 40,000 employees. Mr. Maxwell's responsibilities include oversight in the development of the annual budgets for the 15 agency departments and boards. He also oversees development of policies and program implementation undertaken by these departments.

Mr. Maxwell-Jolly received his B.A. in history and political science from Indiana University, his M.P.H. from the University of Michigan, and his Ph.D. in public policy analysis from the RAND Graduate School. He has taught at the University of Southern California's School of Public Management and at Pepperdine University. His publications include *California's Welfare Dynamic* (1989), *"How California's Welfare Dynamic Affects Work Programs Such As GAIN"* (1987), *A Review of California's Child Support Enforcement Program* (1985), *Public Assistance in California: Facts and Figures* (1984, co-authored), and *Legislative Options for Developing Welfare Computer Systems in California* (1983).

Kristen Testa, Assistant Secretary for Health Programs and Fiscal Affairs
Kristen Testa was appointed Assistant Secretary, Program and Fiscal Affairs by Governor Gray Davis on March 30, 2000. Ms. Testa serves as Assistant Secretary to the Managed Risk Medical Insurance Board (MRMIB), Medi-Cal within Department of Health Services (DHS), Emergency Medical Services Authority (EMSA), California Department of Aging (CDA), and the Office of Statewide Health Planning and Development (OSHPD).

Prior to her State appointment, Ms. Testa worked for the U.S. Senate, Committee on Finance from 1997 to 1999, specializing in legislation on Medicaid and Children's Health Insurance Program (CHIP). From 1993 to 1997 Ms. Testa worked for the U.S. Department of Health and Human Services in the Office of the Secretary analyzing and developing Medicaid and cash assistance policies. From 1992 to 1993 she was a Health and Social policy analyst for Families USA Foundation.

Ms. Testa received her Bachelor of Science degree in Biology in 1989 from Tufts University in Massachusetts. She continued her studies at Johns Hopkins School of Hygiene and Public Health in Maryland where she received her Masters Degree in Health Policy in 1993.

Ms. Testa will serve as the Agency's lead, and will be assisted by an in-house Project Manager contractor hired in early September.

Andrew Grow, Special Assistant, Communications and Planning
Andy Grow serves as a special assistant in the Health and Human Services Agency, focusing on external affairs and strategic planning. Mr. Grow has more than 19 years experience working in and around government, public policy and public outreach.

Prior to joining the Agency's staff in May, 2000, Grow was legislative assistant to a Seattle City Councilmember, where he specialized in low income housing, human services, homelessness and media relations. Before joining the City Council staff, he was a communications consultant in Seattle, advising clients on communications strategy, public opinion research and media relations. Prior to moving to Seattle, Grow served four years as administrative assistant to a Sacramento County Supervisor, and five years as an aide to a member of Congress from Northern California.

Mr. Grow will assist Ms. Testa with management and coordination of project activities.

California Research Bureau

Charlene Wear Simmons, Assistant Director, California Research Bureau
Charlene Simmons oversees the General Law and Government Section of the California Research Bureau, a non-partisan research and policy agency within the California State Library. Dr. Simmons provides policy advice and issue development to State legislators, the Governor's staff, Agency secretaries and other high-level policy staff on topics such as government structure and management, economic development and consumer issues, health, family law and policy, and Mexico and border affairs. Dr. Simmons began her tenure with the California Research Bureau in 1992, when she managed the team charged with building the new organization, establishing policies and procedures, hiring and training research staff, and developing quality research projects and materials. Dr. Simmons is the author of numerous research papers and has provided expert testimony in legislative and executive policy briefings. Her expertise is in maintaining current knowledge of academic research in a wide range of areas, and bringing this literature into the public policy process.

Prior to her current appointment, Dr. Simmons was the Senior Consultant to the California Assembly Select Committee on Ethics, where she wrote legislation, planned hearings, supervised the committee staff and budget, and implemented new ethics education requirements for legislators, staff and lobbyists.

Dr. Simmons received her Ph.D. in Political Science in 1986, and her Bachelor of Arts degree in Spanish and Political Science in 1968, from the University of California, Davis.

Dr. Simmons would provide oversight and direction to the CRB/CAFIS team participating in the project.

Ginny Puddefoot, Director, California Family Impact Seminar
Ginny Puddefoot manages the California Family Impact Seminar within the California Research Bureau. This public/private partnership develops and implements policy seminars and other

forums in a non-partisan environment to allow high-level policy staff and other interested individuals to discuss current research and its policy implications for children, youth and families. Since coming to the California Family Impact Seminar in January 1999, Ms. Puddefoot has developed and implemented seminars on several topics, including welfare reform and child welfare, and education and employment gaps for Latino children, youth and families.

From 1993 to 1998, Ms. Puddefoot was the Public Policy Program Director for the Foundation Consortium, a collaboration of fifteen California-based philanthropic organizations committed to improving the lives of children, youth and families. She designed and implemented major public policy initiatives, including an annual Statewide policy conference and the County Partnership Project, a multi-year collaborative effort to promote innovative, integrated approaches to providing services to children and families. From 1988 to 1993, Ms. Puddefoot served as a Senior Fiscal and Policy Analyst in the Health and Welfare Section of the California Legislative Analyst's Office.

Ms. Puddefoot received her Bachelor's of Science degree in Applied Earth Sciences in 1980 from Stanford University. She continued her studies at the University of California, Berkeley, where she received her Masters degrees in Public Policy and Public Health in 1988.

Ms. Puddefoot would be responsible for coordinating the development and implementation of the symposia, including the public outreach strategy; the development and maintenance of a website for the project; and production and distribution of background reports and symposia summaries.

Joel Cohen, Senior Policy Analyst, California Research Bureau
Joel Cohen provides policy research and technical support to legislators and staff, the Governor's staff, and Agency representatives on education and health policy issues. Mr. Cohen's recent areas of research include an analysis of breast cancer survival rates and health plan services, factors affecting childhood obesity in diverse ethnic populations, and children's perspectives on school safety and violence. Mr. Cohen developed a methodology for conducting original research using a focus-group format that is currently being adopted by other researchers within the California Research Bureau.

Prior to joining the California Research Bureau in 1998, Mr. Cohen was a Research Analyst for the New York State Senate Majority Leader's Office. During his ten-year tenure in this position, he conducted in-depth research and analysis on policy issues, prepared background reports, drafted legislation, and provided policy advice to the Office.

Mr. Cohen received his Bachelor of Arts degree in Economics from Yeshiva University, and a Masters degree in Urban and Regional Planning from the State University of New York at Albany.

Mr. Cohen would be responsible for compiling and analyzing current research and analyses on approaches to providing health care coverage to the uninsured, and would assist CHHS in identifying and developing databases for use by the researchers and modeling contractor participating in the project.

SECTION 6. BUDGET PLAN

The table below itemizes the elements of the proposed budget for the project.

HCOP BUDGET PLAN

	Federal	Non-Federal*	Total
Development and Implementation of Data Collection Efforts	***$12,500***	***$125,000***	***$137,500***
Identify and facilitate access to existing State data bases	0	75,000	75,000
Review literature and prepare background papers	0	50,000	50,000
Print and disseminate background papers	12,500	0	12,500
Development and Implementation of Analysis of Approaches	***$587,500***	***$50,000***	***$637,500***
Commission 10 papers on options	100,000	0	100,000
Technical assistance with framework and model development	25,000	0	25,000
Contract for quantitative research, modeling, comparative framework, and comparative analysis report preparation	450,000	0	450,000
RFAs for option papers and model development	0	50,000	50,000
Print and disseminate report	12,500	0	12,500
Development, Presentation and Discussion of Options	***$210,000***	***$0***	***$210,000***
Conduct 5 policy symposia to present and discuss option papers	150,000	0	150,000
Contract for public outreach, website development, and other mechanisms to ensure participation by stakeholders	50,000	0	50,000
Equipment rental (e.g., presentation audio/visual, graphics)	10,000	0	10,000
Production of Final Products	***$25,000***	***$35,000***	***$60,000***
Prepare final report summarizing options, comparative analysis, and stakeholder perspective	0	35,000	35,000
Disseminate final report to HRSA, Legislature, and others for use in SB 480 and future related activities	25,000	0	25,000
Personnel Costs	***$177,000***	***$150,000***	***$327,000***
Project Staff (CHHS and other State agencies)	0	150,000	150,000
Project Consultant Contract (Health Care Expertise)	85,000	0	85,000
Project Associate (research and symposia development/assistance)	30,000	0	30,000
Student Assistant (coordination of symposia logistics)	12,000	0	12,000
Consultants, technical advisors for data synthesis and analysis	50,000	0	50,000
Evaluation Costs	***$10,000***	***$0***	***$10,000***
Contract for project evaluation	10,000	0	10,000
Subtotal, Direct Charges	***$1,022,000***	***$360,000***	***$1,382,000***
Indirect Charges	***$175,000***	***$62,000***	***$237,000***
Grand Total	***$1,197,000***	***$422,000***	***$1,619,000***

***Includes $200,000 from the State General Fund and in-kind contribution of existing State resources.**

Data Collection Activities. This includes the compiling of existing State databases from the Department of Health Services (including Medi-Cal), Major Risk Medical Insurance Board, Department of Mental Health and other State agencies, and identifying data gaps that need to be addressed for the project to proceed. They also include collecting and analyzing the latest research on approaches for providing coverage to the uninsured.

Analysis of Approaches. This includes preparation of RFAs for the research papers and modeling contract, convening of a Technical Advisory Committee (TAC) consisting of experts in the field, review of draft materials by the TAC, and development of matrices comparing features of the different approaches. The modeling is designed to translate the conceptual papers into real, data-driven analyses of each approach's effects on California's uninsured population, economy and other key factors identified by the TAC.

Development of Options. The Project is designed to elicit broad public awareness and debate about the approaches and analyses developed for the project. They include a series of symposia to present the approaches, followed by panel discussion and public dialog. These symposia would be supplemented by development of a website and additional collateral materials as needed.

Production of Final Products. The project developed for the HRSA grant builds on a current effort underway as a result of the passage of SB 480. The reports developed for this project would be widely disseminated and would form the centerpiece of future activities by the State to reduce the number of uninsured.

Personnel Costs. The existing staff within the CHHS and other State agencies would not be adequate for developing and implementing the project as envisioned. Additional project staff and occasional consultants would be necessary for successful completion of the project.

Evaluation Costs. These activities would be integrated into all aspects of the project.

Management of Grant Funds

Management of funds and the monitoring of the budget for the Project shall be the responsibility of the project manager. Grant funds will be deposited in the Agency account that is under the supervision of the State Controller and the State Department of Finance. With the assistance of the Agency's Executive Secretariat, the project manager will monitoring project expenditures to make sure that the Project resources are spend appropriately and within budget.

Non-Supplantation of Existing Funding

Funding under this HRSA grant will complement rather than supplant efforts by the State to review options for expanding health coverage. The CHHS is required by statute to review health care coverage options. The 2000–2001 State budget appropriated $200,000 of State General Fund to the Secretary to do this task. The grant funding provided by HRSA provide support that will make a substantial improvement over what could be accomplished with only State funding and other in-kind support. The HRSA grant will allow more thorough development and analysis of the options under consideration. This extra effort will mean that the discussion of the value and feasibility of a particular reform option will be grounded in reasonable assessments of what is likely and possible under that particular option. In addition, support from the HRSA grant will permit broader stakeholder discussion of the options and more extensive public comment.

SECTION 7. EVALUATION PLAN

The Project will include several evaluation components to assess progress, to identify potential problems, and to provide an overall review of the Project for State policy makers and for HRSA. These include evaluation of (1) overall progress and keeping the project on schedule, (2) the quality of the symposia, (3) stakeholder assessments of the outcome of the project.

Assessment of overall progress

The project management matrix, with its goals and objectives, provides the basic structure for the results-based portion of our evaluation and forms the starting point for the evaluation itself. All phases of the evaluation are the responsibility of the Project Manager in conjunction with a contract evaluator. The Project Manager will report monthly to the Deputy Secretary of the Health and Human Services Agency regarding success in meeting the milestones identified in the management matrix. The project manages will also provide recommendations for changes necessary to address problems identified during the month. This component of the evaluation will provide an overall assessment of the project and uses the identified goals and objectives both to create a progress reporting process and to provide the basic data with which to assess results.

Evaluation of the symposia

The second component of the evaluation is an assessment of the symposia, which are a critical element of this project. The California Family Impact Seminar (CAFIS) will contract separately with a qualified independent researcher to conduct an evaluation of the proposed symposia. This evaluation would include the use of survey questions and follow-up interviews. The evaluation would give all symposia participants the opportunity to provide feedback as to the quality of the options presented, whether each symposium met their information needs and expectations, and whether they were provided an opportunity for meaningful participation in the policy discussion.

CAFIS would distribute survey questionnaires at each seminar. The questionnaire would include questions about the relevance of the topic, the usefulness of the information presented, the objectivity of the presenters and the quality of discussion and debate. Questions about the symposia format itself would include questions concerning logistics: the time, place, length of presentations, and the time available for discussion. The surveys also might solicit suggestions for future symposia topics. Finally, the evaluator would collect and analyze data on the number and affiliation of participants attending the symposia.

This evaluation also would include interviews of a random sample of participants from each symposium to ascertain their opinions regarding the value and contribution of the symposium to their work and to the public policy debate. Following the symposia series the evaluator would include an overall assessment as to the value the symposium approach.

Stakeholder assessment

Since an important part of this project is stakeholder involvement, the evaluator will design and implement a stakeholder assessment component to the overall evaluation contract. This component is separate from the symposia evaluation since stakeholder participation occurs

throughout the project in a variety of ways. The primary research questions for this component include whether there has been sufficient, appropriate, and useful stakeholder involvement. This will include interviews with members of the Technical Advisory Committee and stakeholders. Also, the evaluator will analyze the records produced at the symposia, and administer supplemental surveys, either as a component of the symposia evaluation or separately based on a sample.

The self-evaluation will provide much of the information required by HRSA, however, the Project commits to participating with HRSA and the other planning grant States in an overall evaluation of the projects. Such participation would include discussions both about the design of the overall evaluation and about data collection requirements.